

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010887</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/04/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>STERLING HOUSE OF MERRILLVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8253 VIRGINIA ST</b> <b>MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00147114.</p> <p>Complaint IN00147114- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 3 and 4, 2014</p> <p>Facility number: 010887 Provider number: 010887 AIM number: N/A</p> <p>Survey team: Regina Sanders, RN</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Census payor type: Private: 37 Total: 37</p> <p>Sample: 3</p> <p>Sterling House of Merrillville was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN147114.</p> <p>Quality Review 04/04/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE